

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS432AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2010
NAME OF PROVIDER OR SUPPLIER V. NICHOLAS ADULT CARE HOME #2		STREET ADDRESS, CITY, STATE, ZIP CODE 4304 EL CAMINO AVENUE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28276 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 2/17/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for six Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was six. Six resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed. The facility received a B. The following deficiencies were identified:	Y 000		
Y 070 SS=E	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review on 2/17/10, the facility	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS432AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2010
NAME OF PROVIDER OR SUPPLIER V. NICHOLAS ADULT CARE HOME #2			STREET ADDRESS, CITY, STATE, ZIP CODE 4304 EL CAMINO AVENUE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 070	Continued From page 1 failed to ensure 1 of 2 caregivers received eight hours of annual training (Employee #2). This was a repeat of the 2/11/09 State Licensure survey. Severity: 2 Scope: 2	Y 070			
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A / Tuberculosis NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review on 2/17/10, the facility failed to ensure 1 of 2 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #2). The file for employee #2 failed to contain evidence of an annual signs and symptoms review. Severity: 2 Scope: 3	Y 103			
Y 435 SS=C	449.229(4) Fire Extinguisher; Inspection NAC 449.229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by	Y 435			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS432AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2010
NAME OF PROVIDER OR SUPPLIER V. NICHOLAS ADULT CARE HOME #2			STREET ADDRESS, CITY, STATE, ZIP CODE 4304 EL CAMINO AVENUE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 435	Continued From page 2 a person certified by the State Fire Marshall to conduct such inspections. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation on 2/17/10, the facility failed to ensure 1 of 1 facility fire extinguishers were inspected annually. Severity: 1 Scope: 3	Y 435			
Y 885 SS=D	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation and interview on 2/17/10, the facility failed to destroy medications after they were discontinued, had expired or after a resident had been transferred.	Y 885			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS432AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2010
NAME OF PROVIDER OR SUPPLIER V. NICHOLAS ADULT CARE HOME #2		STREET ADDRESS, CITY, STATE, ZIP CODE 4304 EL CAMINO AVENUE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 885	Continued From page 3 Severity: 2 Scope: 1	Y 885		
Y 930 SS=C	449.2749(1)(a) Resident File-Storage, Res Information NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (a) The full name, address, date of birth and social security number of the resident. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation on 2/17/10, the facility failed to ensure 6 of 6 Resident files were kept in a locked place. Resident files were observed in an unlocked filing cabinet in the family room. Severity: 1 Scope: 3	Y 930		
Y 944 SS=A	449.2749(2) Resident File - Discharge Documentation NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person	Y 944		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS432AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2010
NAME OF PROVIDER OR SUPPLIER V. NICHOLAS ADULT CARE HOME #2			STREET ADDRESS, CITY, STATE, ZIP CODE 4304 EL CAMINO AVENUE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 944	<p>Continued From page 4</p> <p>in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death.</p> <p>This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review and interview on 2/17/10, the facility failed to provide complete documentation regarding a resident who had been discharged.</p> <p>Severity: 1 Scope: 1</p>	Y 944			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.